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ABSTRACT

Written for Iowa's school psychologists, the report examines current issues in mental retardation including the problem of definition, court actions affecting the schools, and trends in educational programming, evaluation, and diagnosis. Considered are reasons why mental retardation is difficult to define (such as the lack of an acceptable definition of intelligence), historical changes in the definition, and the differences between the 1961 and 1973 American Association on Mental Deficiency (AAMD) definitions. Iowa's current use of the 1961 AAMD definition is discussed. Recent court decisions on due process and service to low functioning children are reviewed as they affect school psychologists. Discussion of educational programming focuses implications of the trend toward the Cascade System of Special Educational Services (a continuum of instructional levels to meet the educational needs of children regardless of traditional labels); on the desirability of mainstreaming; and a special class curriculum and instruction. Effects of the Cascade System and the team approach on the school psychologist's role in identification, evaluation, and diagnosis, and a model process for making intervention decisions are examined. The author suggests that school psychologists become leaders and catalysts in changing professional practices in the education of mentally handicapped children. Listed and described are statewide health, education, and welfare services for the mentally handicapped available in Iowa. (LS)

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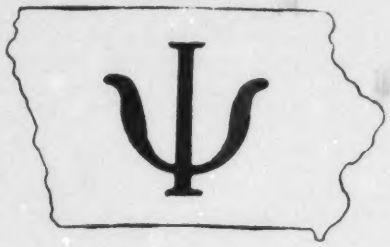

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CURRENT ISSUES IN MENTAL RETARDATION

February, 1974

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Table of Contents

Section	Page
Introduction	1
Problem of Definition	3
Courts and Children	12
Educational Programming	18
Identification, Evaluation and Diagnosis	24
Where Do We Go From Here	31
Bibliography	34
Appendix	36

A. Statewide Resources in Mental Retardation

Introduction

In the last few years there has been a lot of discussion in the literature about what mental retardation is, who the retarded are, and how they should and how they should not be served. For a while there seemed to be extensive polarization, with some professionals seeming to say that special classes were not needed for any population and other professionals seeming to defend the status quo. More recently the discussions have concerned themselves with more refined questions than, "Are special classes as effective as regular classes?", directing attention to such issues as reasons causing special class placement and alternatives to special class placement. Throughout all of the rhetoric, the school psychologist has been caught up in the controversy and confusion because of his role in mental retardation.

As advocates for children, school psychologists have responded to this situation in differing ways. Some have taken sides, attacking or defending the special class model. Others have stayed closer to middle-ground, expressing concern over the way that special classes have often been used, but supporting their use for some children. Some school psychologists have refused to place children in special classes because of their philosophical opposition to them. Others have placed children, but have felt great concern in doing so. In all situations some concern has been registered about the confusion and uncertainty centering around mental retardation.

The purpose of this paper is to help to provide Iowa's school psychologists a perspective on current issues in mental retardation. In the past, the literature has isolated the issues and treated them independently. This may be appropriate for journal articles, but it provides little for the professional wanting to understand the larger picture. Therefore, this paper attempts to present information on the definition of mental retardation and the recent definitional change, court actions affecting us, educational programming, and evaluation and diagnosis. Since these issues are interrelated and collectively affect us, it is necessary to see them together. A danger with any attempt to communicate the broader picture is the possibility of covering the topics superficially. This danger must be risked with the hope that journal articles will provide the depth where this paper is lacking.

This paper is written for Iowa's school psychologists. The selection of content, presentation of implications, and suggestions for professional practice are directed to that target population. At the same time, the changes that are occurring or that are needed in mental retardation involve more than the school psychologist. Policy makers and practioners at all levels are involved to varying degrees. But since the school psychologist is involved when mental retardation is suspected, it is he who feels the pressure where policy and practice are less than they should be.

It would be easy to write about some of the issues related to mental retardation, e.g., misplacement of minority children, in a very emotional, indignant manner. Hopefully, such an approach has been avoided. It is not that we should be less than indignant about what has happened to some children, but that such an approach would cloud the issues, making it more difficult to understand and resolve the basic problems that exist.

Also, an attempt has been made to be practical in presenting implications and possible courses of action. It would be possible to advocate continuous progress types of instruction in all schools so every child could develop at his own rate without receiving pressure for being different. Or, it would be possible to advocate the abolishment of traditional categories such as mental retardation, learning disabilities, emotionally disturbed and so forth. Both have merit and philosophically we may be committed to them. Unfortunately, Iowa's schools are too far away from achieving a continuous progress model for this to be a practical suggestion. Facilities, personnel, curriculum, instructional materials and philosophy have yet to come together to make that possible. Also, from a political and economic standpoint, abolishment of the current categorical funding system seems unlikely. The possible consequences of such a change are so great, both good and bad, that I would hesitate to endorse such a structural change until I was certain that the outcome would improve services to handicapped children. The changes suggested to you are hoped not only to improve services to children, but also to be those things that you can realistically begin to work on today.

You are encouraged to read the following sections critically. The issues in mental retardation are complex and I do not pretend to be less baffled about what is the most desireable courses of action than others. What is presented to you is my best thinking at this time; thinking that has been shaped by my experience with Iowa's schools and school psychologists while I was a part of the Department of Public Instruction. Hopefully, you will find the information provided useful in improving your services or as a stimulus for you to use in generating better alternatives for professional practice.

THE PROBLEM OF DEFINITION

No professional must cope with the problem of defining mental retardation more than the school psychologist. It is the school psychologist who is charged with the responsibility of certifying that a pupil is mentally retarded and thus eligible for special education services. Because each diagnosis of mental retardation is so important, it is essential that the complexity of the definitional issue be understood.

The problem of developing a workable definition of mental retardation is compounded by three basic factors. The first is that mental retardation covers a wide range of intellectual functioning. Not only are individuals who are obviously intellectually subnormal included, but also included are individuals who function reasonably well in non-academic and non-problem solving situations. Because of this wide range of functioning it is necessary to subdivide retardation into levels. Without such delineation of mental retardation into levels it would be impossible to discuss any aspect of retardation with specificity.

A second problem area is the variety of disciplines interested in mental retardation. The physician, social worker, psychologist, sociologist, educator, lawyer, rehabilitation counselor as well as others are all interested in mental retardation. Since each looks at the individual from a different point of view, what one discipline defines as retarded behavior, others may not. This lack of consistency, which is not necessarily bad, does make it possible for interdisciplinary communication and understanding to be impaired.

The third problem affecting the definition of mental retardation is our inability to arrive at an acceptable definition of intelligence. Since mental retardation is connected to intelligence, a definition of intelligence that could be used universally as a basis for determining mentally deficit behavior would be helpful. Unfortunately, at this time there is no single definition of intelligence that is accepted.

The only significant effort to define intelligence occurred in 1921. The Journal of Educational Psychology invited 14 specialists in the area of individual differences to present their views on the nature of intelligence; while some commonality existed, each presented a definition in some respects different from the others. No real attempt to achieve consensus on the definition of intelligence has since occurred. In essence, this definitional void has permitted intelligence to become that which is measured by the intelligence tests. While the usefulness of standardized tests in identifying individuals capable of scholastic achievement cannot be questioned, progmatic success has not filled the theoretical void that would be useful in defining mental retardation.

With some of the problems associated with formulating a definition in mind, let us examine some of the earlier definitions of mental retardation. When Sequin became superintendent of the Pennsylvania Training School in 1848, basis for mental retardation was limited to specific, observable and gross deviations from the normal. Moving forward in time almost one-hundred years, Tredgold in 1937 described mental retardation as:

> "a state of incomplete mental development of such a kind and degree that the individual is incapable of adapting himself to the normal environment of his fellows in such a way as to maintain existence independently of supervision, control or external support." (Robinson and Robinson, 1965, p. 29).

While obviously more precise than that which existed during Sequin's time, it was general and oriented toward the individual as an adult.

Doll, in 1941, offered a different definition of mental retardation. As can be seen from his definition, he stressed origin of the handicap, cause and incurability. He stated:

> "We observe that six criteria by statement or implication have been generally considered essential to an adequate definition and concept. These are (1) social incompetence, (2) due to mental subnormality, (3) which has been developmentally arrested, (4) which obtains at maturity, (5) is of constitutional origin and (6) is essentially incurable." (Robinson and Robinson, 1965, p. 30).

Kanner offered a different view of mental retardation in 1948. Although still looking at adult functioning, he stressed the relationship of the environment to the handicap. He divided the condition into two types: absolute and relative retardation. Absolute retardation referred to those individuals who are so severely limited that they would be ill-placed in any society. Conversely, relative retardation referred to those individuals whose limitations are related to the societal standards that exist and demands that are placed on the individual. It is assumed that if the individual lived in a less complex, less academically oriented environment that the limitations would not be apparent.

Using the earlier definitions as a reference, we can examine the definition that we have been using, i.e., the one developed by the American Association on Mental Deficiency. The definition, developed by the AAMD with the support of the National Institute of Mental Health in 1959 and revised in 1961 states:

> Mental retardation refers to subaverage general intellectual functioning which originated during the developmental period and is associated with impairment in adaptive behavior. (Heber, 1961, p. 3).

Each part of the definition is specifically defined. The AAMD Manual on Terminology and Classification (1961) defines the terms as follows:

> Subaverage refers to performance which is greater than one Standard Deviation below the population mean of the age group involved on measures of general intellectual functioning. Level of general intellectual functioning may be assessed by performance on one or more of the various objective tests which have been developed for that purpose. Though the upper age limit of the developmental period cannot be precisely specified it may be regarded, for practical purposes, as being at approximately sixteen years.
>
> The definition specifies that the subaverage intellectual functioning must be reflected by impairment in adaptive behavior. Adaptive behavior refers primarily to the effectiveness of the individual in adapting to the natural and social demands of his environment. Impaired adaptive behavior may be reflected in: (1) maturation, (2) learning, and/or (3) social adjustment. These three aspects of adaptation are of different importance as qualifying conditions of mental retardation for different age groups. (Heber, 1961, pp. 3-4).

The manual goes on further to define the three aspects of adaptive behavior which will not be discussed here.

In looking at the 1961 AAMD definition it is helpful to note differences from earlier definitions. A major departure is that it is developmental in nature. It permits an individual to be viewed at any stage of development and a decision reached regarding the presence of mental retardation. Accompanying this is the stress placed on current functioning only. The definition views only present functioning and does not attempt to predict the future status of an individual. Therefore, by definition, an individual may be classified as mentally retarded at one point in time, but not at another. Measurement is implicit both by the specification of minus one Standard Deviation below the population mean and the requirement that it be on a general, rather than a specific, test of mental ability. Functioning is viewed far broader than results of a test score. Diagnosis of mental retardation requires that impairment in adaptive behavior must accompany subaverage general intellectual functioning for an acceptable diagnosis to be made.

As we all know, the practices of public education in placing children in classes for the mentally retarded have been questioned. A major issue raised has been diagnosis based on a single test score and lack of consideration for environmental or ethnic influences on student performance. It should be observed that the errors lie with questionable practices rather than with the definition of mental retardation. The definition is sufficiently clear about impairment in adaptive behavior having to occur concommitantly with lowered intelligence. While it is rare that it is stated, some basic assumptions have always existed underlying testing and assessment:

1. Examines knowledge and skill,

2. Appropriateness of the assessment technique to the subject,

3. Consideration of errors of measurement,

4. Comparable acculturation between the test items and the subject, and

5. Obtaining representative samples of behavior. (Smith, 1969)

The relativity of mental retaration that is part of the definition is a different issue and a difficult one with which to deal. Because of differences that exist between school systems and attendance centers children may not be classified as mentally retarded in one situation. However, a change in an educational situation may be accompanied by new demands and a child previously not identified as retarded could become so classified. As unpleasant as such variation may be, as one looks at schools and school systems where the average child is performing significantly below grade level or school systems where the average child is performing significantly above grade level, the reality of the relativity of mental retardation can be understood. In both types of situations (in addition to lowered intelligence) diagnosis would be based on marked inability to adapt, but what constitutes marked discrepancy will depend on the specific situation. Such variation in requirements for adaptive behavior make it most important that mental retardation be viewed as current functioning only and that systematic re-evaluation procedures exist. It is perhaps, in part, the lack of systematic procedures for re-classification that has caused us to be concerned about our educational practices.

The abuses and concerns that exist have resulted in court action that will be discussed in the next section. The feelings of professionals, along with court action, have caused the 1961 AAMD definition to be modified. In 1973 the AAMD definition was changed to the following:

> "Mental Retardation refers to significantly subaverage general intellectual functioning existing concurrently with deficits in adaptive behavior, and manifested during the developmental period." (Grossman, 1973, p. 11)

In looking at the new definition one can see some important changes. The cutoff for eligibility has been lowered from minus one to minus two standard deviations. Therefore, according to the new definition, children who previously have scored between about 70 and 84 on an individual test of intelligence and were classified as borderline mentally retarded are no longer considered to be mentally retarded. The borderline classification (IQ 70-84) has been omitted in the 1973 definition entirely. Although the developmental period has been extended to age 18, the only major substantive change is the upper point at which mental retardation may begin. One may note, though, the increased emphasis on the requirement that adaptive

behavior be impaired by the positioning of that requirement closer to the phrase dealing with lowered intelligence. Adaptive behavior, rather than being categorized into three major areas, has been further delineated.

> "ADAPTIVE BEHAVIOR is defined as the effectiveness or degree with which the individual meets the standards of personal independence and social responsibility expected of his age and cultural group. Since these expectations vary for different age groups, DEFICITS IN ADAPTIVE BEHAVIOR will vary at different ages. These may be reflected in the following areas:
>
> During INFANCY AND EARLY CHILDHOOD IN:
> 1. SENSORY-MOTOR SKILLS DEVELOPMENT
> 2. COMMUNICATION SKILLS (including speech and language)
> 3. SELF HELP SKILLS
> 4. SOCIALIZATION (development of ability to interact with others)
> 5. APPLICATION OF BASIC ACADEMIC SKILLS IN DAILY LIFE ACTIVITIES
> 6. APPLICATION OF APPROPRIATE REASONING AND JUDGMENT IN MASTERY OF THE ENVIRONMENT
> 7. SOCIAL SKILLS (participation in group activities and interpersonal relations)
>
> and
>
> During LATE ADOLESCENCE AND ADULT LIFE in:
> 8. VOCATIONAL AND SOCIAL RESPONSIBILITIES AND PERFORMANCES" (Grossman, 1973, p. 12)

The following statement is provided regarding adaptation during the school years:

> "The skills required for adaptation during childhood and early adolescence involve more of the learning processes. This involves the process by which knowledge is acquired and retained as a function of the experiences of the individual. Difficulties in learning are usually manifested in the academic situation but in evaluation of adaptive behavior, attention should focus not only on the basic academic skills and their use, but also on skills essential to cope with the environment, including concepts of time and money, self-directed behaviors, social responsiveness and interactive skills." (Grossman, 1973, p. 12)

Again, the change can be viewed as an attempt to underscore what seemed to be present in the earlier definition.

It is not the intent here to discuss the desirability of the recent definitional change. Rather, the purpose is to promote an understanding of how the imprecise way the 1961 definition was too frequently implemented has helped to stimulate the change. Such a definitional change may have many possible implications for the public schools in Iowa. Just how children might be affected by the change requires understanding of the substance of the earlier definition and the intent of the change.

	1961 Definition	1973 Definition
1. Mental development	subaverage - 1 S.D. below the population mean	significantly subaverage - 2 S.D. below the population mean
2. Age of onset	birth to about age 16	birth to about age 18
3. Functioning of individual	impaired adaptive behavior must be present	impaired adaptive behavior must be present
4. Diagnostic requirements		
a. intelligence testing	individual test of general intelligence appropriate to the individual	individual test of general intelligence appropriate to the individual
b. evaluation considerations	total evaluation necessary to rule out other possible causes of lowered functioning	total evaluation necessary to rule out other possible causes of lowered functioning
5. Classification of mental retardation	items 1, 2, and 3 must occur concurrently and diagnostic requirements must have been met	items 1, 2, and 3 must occur concurrently and diagnostic requirements must have been met

Comparison of the 1961 and 1973 AAMD Definitions
of Mental Retardation
Figure 1

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Mental retardation in Iowa's public schools

At this time the definition of mental retardation used by the Iowa Department of Public Instruction is the same as the one developed by the AAMD in 1961. This would mean two things. One, the legal definition currently used by Iowa schools is incongruent with the new definition advocated by the major professional organization in mental retardation. Secondly, children who score from minus one to minus two standard deviations on intellectual tests and who also have impaired adaptive behavior may now be classified as mentally retarded for educational purposes which would not be possible if the 1973 AAMD definition of mental retardation were adopted.

It is important that the distinction between a legal and professional definition of mental retardation be made. Any definition adopted by a state agency must be submitted to the Departmental Rules Committee, a committee of the Iowa Legislature. The committee reviews definitions, rules and regulations submitted to them by state agencies to insure that they are both legal and reflect the intent of the legislature. Once approved, the rules, including definitions, take on the force of law. They cannot be changed without submitting proposed changes to the Departmental Rules Committee. While the review procedures for definitional revision within the AAMD were at least as rigorous as that of the legislature, definitions formulated by professional organizations have no legal basis.

Is it good or bad that Iowa has not changed its definition of mental retardation? That is a most difficult question to answer. It must be recognized that public education has never been completely in harmony with the American Association on Mental Deficiency. Terminology and classification systems used by public schools have always differed. The AAMD (1961) sequenced the levels of mental retardation into five categories: profound, severe, moderate, mild and borderline retardation. Public education has generally classified mental retardation into three categories: severly mentally retarded, trainable mentally retarded and educable mentally retarded. Also, while the AAMD has defined the uppermost limit of mental retardation in terms of standard deviations, state education agencies have generally selected a specific score as the upper cutoff point. Iowa has always been philosophically congruent with the AAMD. Adaptive behavior has been the determining factor in classifying pupils as trainable or educable mentally retarded, not rigid IQ scores as in some states.

Communication is one consideration in deciding on the desirability of a definitional change. Most likely there will be a shift in definition used by agencies who have responsibility for institutions and non-school related services for the retarded such as the Iowa Department of Social Services. In addition to possible coordination problems created by having different definitions, cooperative short and long range planning could be complicated by the use of

different statistical bases for computing incidence. Also, a change in definition by the Bureau for the Handicapped, U.S.O.E. must be anticipated. If there is a discrepancy between state and federal definitions, reporting becomes complex and even more difficult. Further, problems could arise in that the state might wish to use categorical federal funds for serving some children that the Bureau for the Handicapped would no longer consider eligible.

More immediate and child centered considerations would exist if a change were made. What would be the status of pupils scoring between minus one and two standard deviations below the mean who are currently enrolled in special classes? Any wholesale return of pupils to the regular classes without providing for decisions to be made on an individual basis would be violating one of our basic principles, i.e., the uniqueness of the individual. Also, the question must be raised, "Are some children who score between 70 and 84 sufficiently handicapped in some Iowa schools to warrant placement in a special class for the educable mentally retarded? If the answer is yes, it would seem that some provision for them to receive special class services would be desirable. It would be hoped that some children who score in that range could be successfully maintained in the regular program with the aid of a resource teacher. Unfortunately, with a definitional change such pupils would not be eligible because Iowa law, like all states, requires that special education funds be used for "handicapped" children. According to the new definition many pupils currently being served would not be considered "handicapped". A possible problem associated with the effectiveness of resource services is using such services for some children who will not in the short range, if ever, be able to work effectively in the regular program without a maximum of support. A blanket decision to serve children with IQ's from 70-84 in resource programs could reduce the effectiveness of resource services. Unwittingly, resource programs could become filled with children who do not get supplemental assistance, but rather a different curriculum from that of the regular program. If that should happen the self-contained classroom with partial integration would be recreated under the name of resource program and children who need intensive, early intervention to successfully remain in the regular program might be denied such service.

An important theoretical question may need to be answered before Iowa reaches a decision on definition of mental retardation. That question is, "Is the intellectual and academic achievement of children in Iowa schools the same as or different from the national population?" This question is noteworthy because if intellectual and academic achievement is higher than national norms, corresponding adjustment in the mean might be appropriate before standard deviations are calculated. A pragmatic approach has been taken by some school districts by lowering the uppermost IQ limit for placement. On the other hand, one can look at some school districts where pupil achievement is extraordinarily high and see pupils who score between 75 and 84 experiencing a great deal of difficulty with the regular curriculum.

We need also to look at the similarity or differences between practices in Iowa and other states. Introspectively, we must ask if the diagnosis of mental retardation has become a safety valve for filtering out minority children, if diagnosis has relied on single test scores, if adaptive behavior has been ignored and if placement of children has occurred before exhausting available resources or options to help the child be successful in the regular setting? If Iowa has been guilty of the abuses reportedly to have occurred in other states, some change would be needed to protect children. Conversely, if practices in Iowa have been more in keeping with what we would subscribe to as sound professional practices, the reason behind a possible definitional change would have to be viewed differently. Regardless, any change should be contemplated as an opportunity to improve services for children. Such an important decision as a definitional change should not be simply a method to prevent poor professional practices from occuring.

Obviously the decision to retain or alter the current definition used by Iowa's schools is a most complex one. At best, the previous discussion probably only touches the surface of the implications of retaining or changing the definition. It is to the benefit of Iowa's children that no hasty change has been made even though making such a change might be acclaimed as progressive and could easily be defended on the basis of maintaining professional uniformity. The domino effect of modifying Iowa's current definition is sobering and necessitates reviewing all alternatives. Until a change is made, the definition of mental retardation found in the Rules of Special Education Explained: II is the legal definition that must be used in Iowa schools.

COURTS AND CHILDREN

Judiciary action accounts for part of the reason for the recent change in the AAMD definition of mental retardation. While concerns expressed in the professional literature mirror court decisions, the impact of the legal decisions are much more far reaching than scholarly rhetoric. Now, the cajoling, convincing and coercing of educational decision-makers to provide services or to modify practices has given way to mandates from the courts. Requests have been replaced by requirements.

The implications for school psychologists can be divided into two areas: serving low functioning children and insuring that due process is provided to all children. Reaction to the intervention of the courts into the province of educators has been mixed. To some the involvement has been intrusionary with the courts involving themselves in an area, i.e., education of children, where they have no expertise and where quality and readiness cannot be commanded. To others, court orders hold promise of new vistas of educational opportunity for children heretofore neglected and of improved services for children who have been denied appropriate alternatives. Regardless of our point of view, court decisions will have an impact on all of us. To specify the exact nature of that impact would require prophetic skills. However, there is evidence that at least some of the demands discussed below will be made on us.

Service to low functioning children

The exclusionary policies of public schools have been judged to be illegal in numerous states. The courts have decreed that all children, regardless of handicapping condition, have a right to a free and appropriate public education. Using the fourteenth amendment to the Constitution as the legal basis, this decision has been reached in two landmark cases, the Pennsylvania Association for Retarded Children v. Commonwealth of Pennsylvania; and Mills v. Board of Education of District of Columbia. As of September, 1973, litigation has occurred or was in process in more than thirty states.

The requirement that ALL children must be served has had an effect on other states and will surely have one on public education in Iowa. Some of the implications of providing an "appropriate education to all" to be aware of are as follows:

> No waiting lists. Parents can no longer be asked to be patient until a vacancy is available for their child to receive service. Just as the parent of a third grade child cannot be asked to postpone school enrollment, neither can the parent of a handicapped child. According to the Code of Iowa, 257.25, special education services and programs must be made to children "... who are or would otherwise be enrolled in kindergarten through grade eight of such schools." Earlier legislation extends this requirement through the high school years.

New forms of assessment. In addition to the obvious implication of having to serve multi-handicapped children and children with severe intellectual limitations, different forms of assessment will need to be used. Because [redacted] children in question have been previously excluded from public education, there is little professional experience from which to draw on to make decisions. Traditional clinical tools seem to be inherently deficit in assessing strengths and weaknesses of the population to be added to the case load of the school psychologist. Instruments that rely heavily on observation such as checklists and rating scales may become more widely used. The field of physical therapy may prove to be helpful in providing a perspective that will be useful in assessing low functioning children. Exactly what new skills will be needed is uncertain, but they will be numerous enough to require some new training of everyone.

New forms of programming. Traditional programs for trainable mentally retarded children will not meet the needs of the new population to be served. Program content will need to be extended downward and new delivery systems designed. Accompanying these decisions must be the formulation of minimum standards. This would include statements on the pupil-teacher ratio, use of para-professionals and requirements for physical facilities. The content specification and establishment of standards cannot be accomplished hastily if reasonableness and quality are both to be considered. For a rural state like Iowa, the problem of programming and standards are compounded by the large geographical area that must be covered to identify a significant number of profoundly and severely handicapped pupils.

Cooperation with other agencies. Because of the uniqueness of the children to be served by the public schools, it may be that public schools will begin to cooperate directly with agencies that already have been serving profoundly and severely handicapped pupils. While previous cooperation has been informal, future cooperation, with the aid of minor statutory modification, could become contractual. For example, it might be that specialized services provided by the Easter Seal Society, United Cerebral Palsy, day care centers and private agencies could be purchased by the public schools. Also, in rural areas where residential programs are necessary, the Department of Social Services may need to provide funding for residential services so that educational services can be provided. Because of the differing quantity and quality of private services throughout the state, much variation will exist in the structure of the cooperative endeavors used to provide services.

Insuring due process

Insuring due process in education may make more generalized and immediate demands on the school psychologist than will the inclusion

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of children who have previously been denied educational opportunity. This is because the issue of due process involves a larger number of children and covers the full spectrum of ability. Also, at every step, due process considerations seem to involve directly or indirectly the activities of the school psychologist.

The Pennsylvania and Mills cases mentioned earlier provide insight into the due process that must be provided. In the Mills case, the court stated that, "Due process of law requires a hearing prior to exclusion, termination or classification into a special program." (Oberbillig, 1973). This requirement, plus the right to adequate programming brought forth in the Wyatt v. Stickney case will mean that educational decisions by professionals will need documentation that will stand the test of public scrutiny (Gilhoal, 1973). While being challenged cannot help but be somewhat threatening, the reasonableness of the demands cannot be questioned.

In turning to the specific implications that exist from insuring that due process is provided for all children, a word of caution is necessary. In developing practical due process steps and their implications it has been necessary to generalize from existing court rulings. As a result of the generalization process, the legal specificity is lost. Therefore, what is being shared is an individual interpretation of due process implications, not one that has been developed by the judiciary.

Due process for children may be viewed as encompassing the following steps.

1. notification of the parents if educational placement is to be altered,

2. right to appeal,

3. right to specification of outcomes,

4. right to evaluation of outcomes.

Notification of parents. If a child is to have his placement altered, that is, to be moved from the regular program offering, the parents must be informed. Certainly this pertains to decisions involving removing a child from the regular class program for special class placement. It is unknown if this also pertains to notification prior to providing itinerant or resource services. It would seem, though, that parents have the right to know throughout the child's school career if he is not achieving satisfactory. Since psychological evaluation is required for eligibility determination for special services and that by law such services are required for children who need them, parents would not have the right to withhold permission for psychological evaluation. The demands of the courts for appropriate education for handicapped pupils applies equally to agents of the public schools and to parents.

Right to appeal. If the school placement of a child is to be altered, the parents have the right to appeal the decision. Appeal procedures differ, but in all cases they originate at the local level and proceed to a neutral, higher level authorized to provide a final ruling. Of interest to the school psychologist is the right of the parent to use all records and information of the public school in formulating the appeal. The confidentiality of psychological evaluations and written reports exists no longer.

It is important that what the courts are saying not be misinterpreted. They are not saying that the regular class placement of children should never be altered. Rather, they are saying that if the school chooses to alter the placement of a child that there be sufficient evidence to support a change and the type of change intended. It is doubtful that this is less than what each of us would expect, or demand, for our own children.

Right to specification of outcomes. If it is appropriate to change the placement of a child, the benefits to be accrued from that change must be available to the parents. Instructional objectives that extend over a semester or a school year would seem to meet the requirement of expected outcomes. A number of states and school systems have developed extensive lists of measureable objectives in all curricular areas so that they might be able to better specify expected pupil outcomes.

Right to evaluation of outcomes. The last step in the due process requirements is the right of parents to receive an evaluation of the outcomes that actually occur from the program change. Again, it is reasonable that if a change is made to benefit a child that evaluation of what actually occurred be done. If the expected child change does not occur, it would not necessarily mean that the placement was inappropriate in the first place because unforeseen variables could have intervened. There is no reason to suspect that the courts would demand precision and exactness beyond our capabilities. What is expected is that sound judgment and reasonable actions, according to the "reasonable man" principle, exist. If the parents are dissatisfied with the results from the placement change, they may exercise their right to appeal. Once again, they would have access to school records in formulating their appeal.

Along with evaluation of the intended outcomes for a child, it is necessary to systematically re-evaluate the appropriateness of the educational placement. This re-evaluation is to insure that the child remain in his present placement or move closer or further from the regular program as warranted based on his current functioning and needs. As can be seen, the due process procedures attempt to insure that decision-making on the educational life of the child is on-going and dynamic rather than singular and permanent in nature.

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Implications of due process. The implications of due process can be viewed in three areas: school-parent communication, professional cooperation and accountability. It would seem that established communication from the school to the home that heretofore has been viewed as ideal and philosophical must occur in practice. No longer can schools wait until a child has repeatedly demonstrated an inability to perform and a decision to change the child's placement has been made to contact the parents. Instead, continuous reporting should occur from the first sign of difficulty and that reporting contain information on efforts being taken to help the child. Obviously, the school psychologist is only a part of such a communication network. Where the network exists and has been in operation, the school psychologist will not be confronted with the dilemma of facing parents who did not suspect that their child was not doing acceptable work in school.

The due process steps require that greater cooperation exist among professionals. Decisions on diagnosis, program modifications, expected outcomes and evaluation must become a team function that involves the school psychologist, teachers, and consultants as well as other personnel. It is unreasonable to expect a school psychologist to be able to justify a placement change without input from teachers and consultants. Likewise, program decisions and evaluation would be difficult if the expertise of the school psychologist was denied the other individuals. Such cooperation will require us to learn how to work as a team, and also time. Teamwork is developed through experience. However, the time must be provided for the team to handle the tasks that exist as it works together. A major change in educational practice arising from the due process requirements must be the allocation of time during the school day to deal with important educational issues. The SPURT program (Support Programs Utilizing Resource Teachers) sponsored by the Iowa Department of Public Instruction has had school time for staffings built into it from the beginning and the reported benefits from those staffings have been most encouraging. Casual meetings among professionals after school hours will not allow the sophisticated educational decisions that are being required to be made.

Responsibility for being accountable permeates the entire issue of due process--accountability for communication, decision-making, programming and evaluation. While tomes have been written on the subject of accountability, there appears to be two considerations that should be mentioned. The first is involvement of parents as members of the team and in the decision-making process. If the school is to be accountable to the parents, the parents being the representative of the child's interests, their involvement should increase the ability to be accountable and potentially increase the outcomes for the child through a coordinated effort.

The second consideration in accountability is recordkeeping associated with team decisions and pupil evaluation. An efficient, but still effective, manner of recording information that pertains to contacts with parents, staff decisions, intended outcomes and evaluation results must be developed. This is perhaps one of the more perplexing hurdles to be overcome. No one wants to amass pounds of paper that have to be sifted through to see what previous actions have been taken, objectives specified and so forth. Yet, there is a current need for documentation that has not previously existed and that cannot be ignored. It must be assumed that like the area of teamwork, experience will provide insights necessary to make recordkeeping effective and efficient.

Summary

It might be possible because of the intricate involvement of school psychologists in the decisions that are made for handicapped children in the schools to be fearful of the activity of the court . While the visibility of the school psychologist may seem to make him a greater target than other special educators, it is doubtful that there is need for concern. It might be observed that no mention has been made of the suits that have dealt with practices that constitute blatant violations of civil rights through unjustifiable uses of standardized tests in altering the placement of children. Because no one would condone ignoring adaptive behavior in placement of children in special classes, that concern need not exist. Also, the due process requirements should enable school psychologists to better accomplish their purposes. With the school having to be able to justify its actions, the due process requirements may serve as a lever to permit children with problems to be staffed early and to make better educational decisions.

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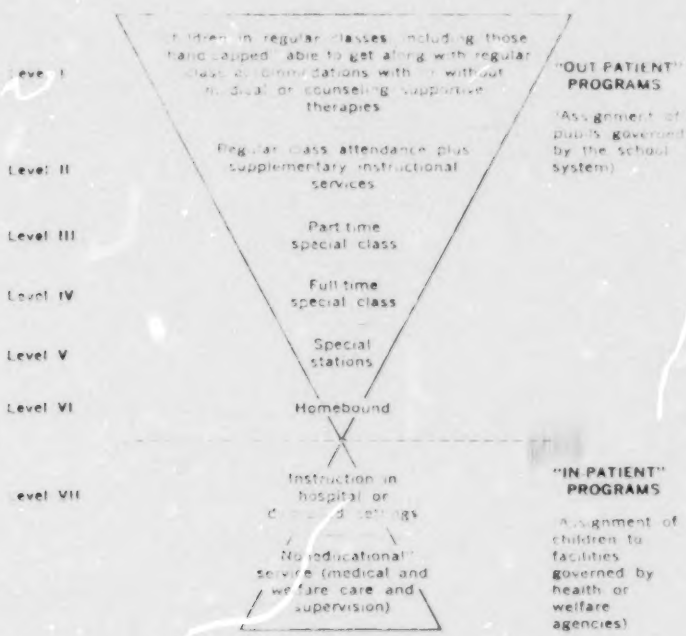
EDUCATIONAL PROGRAMMING FOR THE MENTALLY RETARDED

Ordinarily a discussion of educational programming would follow a section that discusses the identification, evaluation and diagnosis of the mentally retarded. In this case such a discussion precedes the section on identification, evaluation and diagnosis. The reason for this departure from tradition is that significant changes are occurring in the way that educational services for the mentally retarded are beginning to be viewed. These are changes that will have a drastic and hopefully very positive effect on educational evaluation and diagnosis.

The change alluded to is simply the growing commitment on the part of special educators to the philosophy inherent in the Cascade System of Special Education Services (Figure 1). The Cascade or Continuum of Special Education Services presents an instructional model that can be used in looking at the educational needs of children. In looking at the Cascade System, it can be seen that no mention is made of traditional special education categories such as mental retardation, learning disabilities, emotional disturbance and so on. Instead, the Cascade System presents a hierarchy of instructional levels ranging from regular class enrollment with no extra assistance to the child to homebound instruction. This continuum recognizes that regardless of label, children fitting any single psycho-medical diagnosis are not alike educationally. As a group, their educational needs will cover the continuum of special educational services. Also, the type of special education service that a child needs is not static. The child's status may change and movement away from or toward full, unassisted participation in the regular class may occur.

FIGURE 2


Children in regular classes, including those handicapped, able to get along with regular class accommodations with or without medical or counseling supportive therapies
Level I
Regular class attendance plus supplementary instructional services
Level II
Part time special class
Level III
Full time special class
Level IV
Special stations
Level V
Homebound
Level VI
Instruction in hospital or [illegible] settings
Level VII
"No educational" service (medical and welfare care and supervision)
"OUT PATIENT" PROGRAMS
(Assignment of pupils governed by the school system)
"IN PATIENT" PROGRAMS
(Assignment of children to facilities governed by health or welfare agencies)

As one looks at the Cascade System, a tapered design can be seen. This indicates that fewer pupils are in need of more specialized services as movement away from Level I, regular class placement, occurs. Level II may be viewed as including a variety of strategies designed to assist the child in being successful in the regular class program. This would include assistance to the teacher, special materials, and itinerant and resource services. Level III, part-time special class placement, represents the type of program traditionally designed for educable pupils. That is, the core curriculum is provided in the special class setting, but the pupil is selectively integrated into areas such as music, art, physical education and other subject areas where he can be successful. Level IV or full-time special class placement would be the program used for pupils who could not benefit from integration. This, in the past, has included low functioning educable pupils, trainable pupils, severely emotionally disturbed children and others. Special stations, Level V, represents programming that has been found in special schools for the physically handicapped, socially maladjusted, and mentally retarded. Public school programs connected to sheltered workshops, mental health agencies and hospitals would be considered special stations, also. The last level in the education domain is Level VI, homebound instruction. Served at this level would be those children who have not been able to function at a higher level because of factors of health, maturation or social adjustment. Also shown by the Cascade System, Level VII, is the role of non-school services for handicapped children. In-patient programs for children needing highly specialized treatment services that include a residential component offer a starting point for children not able to profit from participation in any of the first six levels. It should be mentioned that a child might need to be at Level VII because of medical or family variables that are independent of educational functioning.

Implications of the Cascade System

A major concern to school psychologists and others interested in the education of mentally retarded pupils has been the results of the efficacy studies. Even though the results have been equivocal and inconclusive at best, a controversy briefly raged regarding whether any educable children should be in special classes. Within a short period of time, the question of special class placement was modified to one of what children, under what conditions and for what purposes should be placed in special classes. The complexity of the special class issue has by no means been lessened. However, the Cascade System offers a different way of looking at special education services for mentally retarded pupils and all other handicapped children. Rather than being locked into an either-or situation, that is, regular class or special class placement, it is possible to see that strategies that provide intervention greater than regular class enrollment with no assistance and less than special class enrollment are available and may be appropriate. Thus, the educable mentally retarded may constitute a diagnostic category, but that category is not a viable instructional grouping. Therefore, the first implication of the Cascade System is that a cascade or continuum of special educational services should be available for all children. Placement of children on that continuum of services is determined by the instructional needs of each child instead of traditional categorical labels.

A second implication of the Cascade System is that educational placement is dynamic and not static. This is consistent with the 1961 and the 1973 definitions of mental retardation. Diagnosis of mental retardation is based on current functioning only and is subject to change, enrollment at any level of the continuum is based on current instructional needs and is subject to change. It would not be unlikely for some children to be successful in an elementary school situation with the help of a resource teacher, but with promotion into junior high or senior high to develop the need for the services of a part-time special class. On the other hand, with advances in career education at the junior and senior high, it might be that some children who need a part-time special class at the elementary level will only need resource teacher assistance at the junior and senior high levels. While generally movement would occur one step upward or downward at a time, in some cases a child might be able to advance more than one level or need to move downward more than one level at a time.

The third implication, a feature not easily seen, is that a child might be participating in two instructional levels at one time. For example, some children in part or full-time special classes may receive the services of itinerant or resource teachers just as do pupils attending regular classes. The exciting aspect of this is that an increased number of alternatives can be viewed when instructional decisions are made.

The fourth implication of the Cascade System is an important one for school psychologists. The courts are requiring that due process be provided to children, i.e., that movement away from the regular program be to only the extent that is necessary to provide the child an appropriate education. The criticism that has been directed at us is that we have been taking a child from the regular class and placing him in a special class without providing other alternatives. Through the use of a continuum concept of services, due process should be provided for since the Cascade System promotes early intervention, and intervention that progresses from a small to a great deviation from the regular program as change is needed.

The fifth implication is that the existence and use of a Cascade System of Special Education Services will make the placement of pupils into special classes easier. The school psychologist has always faced a number of problems in making a decision on whether or not special class placement was needed for a child. These problems have included the validity of tests; the possibility that the problem is situational, that is, it rests with the nature of the regular class instead of the child; the feeling that the child needed help, but not a special class; and the possibility that with maturation the child could function in the regular program. These problems are not minor because placing a child in a special class is a major decision. Special class curriculum is not the same as that offered in the regular class, and once a child is placed in a special class the likelihood that he can return to the regular program and compete academically

is small. As a result, there has always been a tendency to delay placement of children in special classes until sufficient evidence has been gathered that the child cannot profit from the regular program. Sufficient evidence has frequently meant that the child has repeatedly failed in the school situation. Obviously, permitting a child to experience continual failure is not desirable and is deleterious to his attitude toward teachers, school and learning. Because alternatives exist that are less drastic than special class placement, early intervention is encouraged. By observing the progress of the child as he utilizes early intervention strategies, an estimate of his ability to benefit from special materials, curriculum modifications and resource services can be made. If it is seen that the child is not benefiting from regular class attendance with supplemental assistance, then a decision can be made using the child's previous educational functioning and current instructional needs as a reference point. This would constitute a much fairer assessment of adaptive behavior for the purposes of classifying school children as mentally retarded than what we have used in the past.

In summarizing the importance of the Cascade System, it might be said that it represents the beginning of a new era in special education. Rather than being locked into rigid, psycho-medical classification systems as we have been, we are provided a vehicle, a frame of reference, for looking at the educational needs of children who experience problems in school. Instead of having to view all mentally retarded pupils as needing special classes or all learning disabled children as needing resource rooms, we are required to select the most appropriate intervention strategy for each child. The Cascade System is especially important to the field of mental retardation. Since we see mental retardation from an educational viewpoint, it provides a functional system for assessing adaptive behavior and stresses, as does the definition of mental retardation, current functioning only.

The desirability of mainstreaming.

Mainstreaming has taken on almost mystical qualities for some educators in the last few years. Returning all handicapped children to the regular program has been the goal. Philosophically this is the goal of special education, but unfortunately some have approached the goal not as a philosophical one, but as one that is concrete and immediately obtainable. Nationally, there have been children in some special classes that have been returned in mass to the regular program and the special classes dismantled. Also, some school psychologists have taken the position that no child should be placed in a special class because special classes are the antithesis of mainstreaming.

No one could question that returning of children ill-placed in special classes to the regular program or that maintaining children who can benefit from the regular program in that placement is desirable. A top priority of the Bureau for the Handicapped, USOE is services to mildly handicapped children, those pupils who can benefit

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from the regular program with special assistance. Looking at the Cascade System as a reference this would seem to be appropriate because the largest number of children with problems are in that area.

What is disturbing is the narrow definition that seems to have been applied by some to the concept of mainstreaming. To some, mainstreaming is "keeping all children in the program of regular education." A more appropriate definition of mainstreaming might be, "providing the most appropriate education for each child in or as close to the program of regular education as possible." It would seem that this second view of mainstreaming permits us to consider the benefits the child receives from his educational experience and the first one does not. Even without the emphasis of the courts on "appropriate education", it would seem incomprehensible that having children in regular programs without learning occurring could be justified on any basis.

Special class curriculum and instruction

Curriculum can be viewed as the objectives of the educational program and instruction as the methods by which the objectives will be accomplished (Meyen, 1971).

The lack of specific objectives and prepared curriculum materials that special class teachers can use has presented major problems in mental retardation. Specifically, it has permitted the objectives of the educational program to be determined by each special class teacher. In contrast to the regular class teacher, the special class teacher has had to determine the objectives, sequence them, gather or develop materials and then select the instructional strategies; while the regular teacher has only needed to devote her energies to the methods of accomplishing the objectives. In the best of circumstances, where special class teachers have been effectively accomplishing all those tasks, good instruction has occurred, but an uncoordinated sequence of instruction between classes has existed. In less than the best of circumstances, the overall relevancy of the child's school experiences has been lacking.

This problem of coordination of the special class curriculum and sequence of instruction has not been totally alleviated. Fortunately, some very positive changes are occurring. There has been an increasing amount of commercially prepared material available that has relevancy to pupils needing a special curriculum. Because of this, improvement in curriculum has been occurring. In addition, the Bureau for the Handicapped, USOE has been funding projects that have been developing curriculum for special classes. At this time there are four such projects and they cover the content areas of science, social learning, arithmetic and physical education. Iowa has been field testing the science and the social learning curriculum over the past few years. A preliminary judgment based on Iowa field testing is most encouraging and within a short period of time students in special classes should be able to progress through a good K-12 program using curriculum and materials designed for them.

The contact persons for information on the curriculum development projects are listed below. The only curriculum material that is currently available for purchase is the science program.

ICAN Project
Janet Wessel, Director
Michigan State University
Department of Health, P. E. and Recreation
East Lansing, Michigan 48823

J. F. Cawley
Math Project
University of Conneticut
Storrs, Connecticut 06268

Herbert Goldstein, Director
Curriculum Research and Development Center
Yeshiva University
55 Fifth Avenue
New York, New York 10003

BSCS Science Program for the Mentally Retarded
Hubbard Scientific Company
2855 Shermer Road
Northbrook, Illinois 60062

The problem of deciding what the outcomes of instruction should be for pupils in special classes will not be totally resolved by prepared curriculums. Even with the best field testing, materials cannot be developed that will meet all the needs of every pupil in a special class. While we can hope for a more effective overall program, there will still be many decisions left for school personnel. This is to be expected since the pupils needing special class placement are those with more than minor learning and adjustment problems.

It is in this decision-making process that the school psychologist may find one of his most challenging roles. This is the role of deciding the learning outcomes to be expected from placing or continuing the placement of a child in a special class. This will be a cooperative role in which many professionals, and perhaps the parents, provide input and assist in determining instructional goals. This decision-making process is related to evaluation and diagnosis and is discussed in the next section.

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IDENTIFICATION, EVALUATION AND DIAGNOSIS

Some children who are mentally retarded enter school with their condition already having been brought to the attention of the public school. As a group, children functioning in the moderate range of mental retardation or below tend to be identified during the preschool years. This changes the focus of the school psychologist from identification of mental retardation to that of determing proper placement of the child on the Cascade System and that of providing useful information to the teacher. This self-identification process also may be true for some children who would be classified as educable mentally retarded. However, the bulk of the mentally retarded children in the public schools enter and are not suspected of low intellectual functioning until they begin formal academic activities.

The approach to identifying school age children who have low mental ability has changed over the last decade. When special classes were in their infancy in the public schools, there was an active attempt to identify children who might be educable mentally retarded. Various screening procedures to isolate high risk children using group scores from intelligence and achievement tests, plus the use of class profiles or rankings developed by teachers found widespread application in the schools. The role of the school psychologist at that point in time tended to be one of verification. He verified that certain children did in fact have a low IQ and thus should be placed in a special class for the mentally retarded. Our point of view about placement of children in special classes and the role of school psychologist has changed greatly since that time.

It is doubtful that there is the desire or the need to approach the identification of children with low mental development as we have in the past. Courts have expressed their concern about the use of group and individual tests as determiners of children's educational placement. School psychologists appropriately reject demands for testing that are not accompanied by expectations of acquiring information that will be helpful to the child.

Our purpose now is to identify children who are experiencing school difficulties as soon as those difficulties arise. The Cascade System of Special Education Services serves as a filter in this identification process. Because there are alternatives available for children in the regular class who are experiencing difficulty, there are practical reasons to expend the energy to identify them early. A continuum of services for children with problems might also make practical use out of the results of standardized achievement tests. If what is taught is measured by the achievement tests, these results could provide one method by which the adaptive behavior of children in academic areas could be observed. The emphasis of screening is placed on locating children experiencing school difficulty,

not children with low mental ability. The school psychologist is given the question, "Are there identifiable reasons for the child's difficulty and what type of programming would be most appropriate for him?" This question is greatly different than, "Is he eligible for a special class?"

Evaluation of children suspected of mental retardation

The evaluation process requires more than psychological testing. This is stressed in university training programs and also in the state regulations governing diagnosis of handicapping conditions. Too often this requirement is viewed as another state regulation, something else that impedes the delivery of services. At the same time, the rationale for requiring an evaluation of the child's vision, hearing, speech and general health is obvious. Diagnosis of any condition requires that other causal factors be eliminated before a diagnosis is made. While low incidence conditions causing poor school performance may be small in number, they are frequent enough to cause alarm if there is failure to investigate them. Also, if the school psychologist is an advocate for children, he may be in the strongest position to require or facilitate minor corrections that have a bearing on the child's performance, even if such corrections have no bearing on diagnosis. It should be mentioned that evaluation precedes diagnosis, so a broad view of evaluation is warranted for all children being studied because of school problems.

Such an approach to evaluation requires the functioning of a team. This would include the speech and/or hearing clinician, school nurse, and the school psychologist. In most cases the full participation of a physican, while desirable, would not be feasible and consideration of the child's general health would be based on his being under the care of a family physican, school attendance and opinions of the school nurse. Certainly, where there was any question about the possible contributing nature of poor general health to the child's functioning the active involvement of the physican would be sought. Also involved in the evaluation would be the regular class teacher and other personnel, such as consultants, who could offer information based on experience with the child or obtained through conducting academic assessment.

The heart of the evaluation is not the independent activities and information gathering of the various individuals, but the pooling of information and cooperative decision-making. It is interesting that an emphasis on interdisciplinary teaming is not new and has been discussed in the literature for many years. It is the implementation of the Cascade System of Special Education Services that will take such an approach out of the clinics and both require and provide the opportunity for it to be used in the schools. It is only when there is more than one decision that can be made that such a decision-making approach will be used in the schools.

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Diagnosis and team responsibility

Evaluation of the child by various individuals with differing types of expertise can easily be supported. A variety of information is needed if a sound decision is to be made. The question is, "A decision made by whom?" The Rules and Regulations of Special Education Explained: II indicate that it is the responsibility of the school psychologist to certify that the child is eligible for special services as a result of being mentally retarded. At one time this was the major role of the school psychologist, certifying eligibility. Now, because of the increased number and kind of personnel available and an emphasis on making much more refined instructional decisions, the school psychologist is asked to and has the opportunity to use the expertise of others. A problem will exist unless the diagnostic decision is viewed as a team function, rather than the decision of a single individual, the school psychologist. One can imagine the attitude of professional colleagues if diagnosis and resulting instructional options rest with one individual who can determine the outcome regardless of the opinions of others. In such an environment, the professionals will never develop into a functioning unit.

A dilemma exists in that there are certain criteria for mental retardation that must exist to which only the school psychologist can respond. No diagnosis of mental retardation can be made unless the school psychologist, through observation and formal evaluation, indicates that lowered intellectual functioning is present. Beyond that is the whole area of adaptive behavior. If the child has lowered intellectual ability, who should determine if adaptive behavior is impaired? It seems only reasonable that this is the area in which other individuals have the most to contribute and where a group decision is the most important. The danger of such an approach is that in some circumstances the school psychologist, who has had the only vote in the past, may have the only descenting opinion in a diagnostic decision. However, there is absolutely no way that this can be avoided if team functioning is truly sought.

The implication of such an approach to determing a diagnosis is that the psychologist, as representative of the team, must have to certify that a child is mentally retarded in a situation where he has doubts. The one factor that has not been mentioned is that the readiness for all areas of Iowa to approach educational diagnosis of mental retardation in this manner is not the same. The personnel, expertise, agreed on purposes and operating procedures must all be present if such a team approach is to occur. One of the most important leadership roles of the school psychologist might be helping to bring about the conditions where he would feel good about sharing decisions on diagnosis and the accompanying educational decisions.

Because of the repeated and intended emphasis on instruction, diagnostic labels might seem to be unimportant. It is just the opposite though. In Iowa, as in most states, children must be certified as handicapped if they are to receive special education services. The diagnosis of mental retardation should increase offerings to children, not make their school career more difficult.

Using all of the alternatives available in the Cascade System, there are services that the child should be able to receive that permit the label to serve purposes of certifying eligibility without affixing the label on the child. Also, inherent within the definition of mental retardation, if some of our services are effective a child's label of mental retardation can be removed.

Decisions and the team

When decisions that are to be made are discussed in some order, as they must be, it appears that some real, concrete sequence exists. In reality, problem solving, which is what the educational team is engaged in, doesn't occur in a nice, neat order. The advantage of a sequence is that it provides guidance to the problem solving process and where a hypothetical sequence does exist, it prevents the team from prematurely pursuing avenues that might be blind alleys.

The beginning of the process must be consideration of why the child is being discussed at all. It would seem that the largest number of children being seen by the team would be experiencing minor school difficulties. Describing the problem educationally, that is, the current academic or social adjustment that has brought the child to the attention of the team, should allow a decision to be made regarding possible resources in regular education or minor modifications to his school program that would resolve the problem. Involving the teacher or teachers pertinent to the case will allow a reality based discussion of regular education alternatives to occur. The teachers who will be doing the work will be able to respond positively or negatively to the suggestions of others.

If no immediate solution to the problem can be found in the regular program, it will be necessary to gather information on the child and re-describe the problem. By increasing the amount of information gathered on the pupil, that is, using formal testing and observation, as the process continues, professional time can be conserved for the children with the most difficult problems. Hopefully, this additional information and re-description of the program will give the insight necessary to serve the child in the regular program. If not, a decision to be made is whether or not the child is eligible for special education services. The assessment to determine this may have been completed or may still need to be done.

If the child is eligible for special education services the problem should be re-described or the previous description confirmed. Emphasis is placed on the description because if alternatives are to be evaluated, agreement must exist on the nature of the problem. Then, the outcomes desired from some form of intervention must be clearly established. The team would ask, "Is what is being sought improvement in reading, arithmetic, social behavior or a curriculum that stresses self-help skills, oral communication or social adaptation to the community?" When the outcomes are identified, it might be that the existing special education alternatives have nothing to offer. In such a case, it will be necessary to go back to the offerings of the regular program or see that some change is made in the

special education offerings available. There would be absolutely no sense in placing a child in some special education service where it is known before hand that the needs of the child would not be met.

With the desired outcomes of intervention specified, a decision might be made to place the child at one of the levels of the Cascade System for a specific type of service. Such a decision would require certain types of administrative action for the necessary changes to be made. If the principal and the parents have been active participants in the decision-making process, time delay and difficulty should be minimized.

Before an instructional change is made the desired outcomes should be operationalized. That is, the outcomes should be shaped into some measurable form so that it will be possible to evaluate at a later date whether or not they have been met. The date for evaluation of pupil progress should also be established. This will give the teacher, parents and everyone else a time that they can expect the effectiveness of the service to be reported. This evaluation or reporting of effectiveness will provide an opportunity to determine if the current placement on the Cascade System is still appropriate or if a change should be made.

Figure 3 shows a recycling process as part of the system just discussed. The recycling permits desired outcomes to be updated based on new information and previous pupil performance. This creates a basis for future and on-going review of the effectiveness of the special education intervention for the child and appropriateness of his current educational placement.

Implications of a team approach

Any description makes a team process seem to be easier to use than it is in real life. The problems that center around having the expertise needed, ability of team members to work effectively together, and an operating structure to produce results have been mentioned. Even when these problems have been resolved, the teaming process is complex. The largest problem to be faced is that the problems of children that come before the team are difficult ones. As can be expected, minor problems for which resources or alternatives readily exist are programmed for in the classroom or adjustments are made using the regular school channels. Thus, the problems that are brought to the team are those for which a single, best solution will rarely be found. Instead, the team members will be faced with situations where no alternative is entirely free of some features that the team would like to avoid.

School psychologists have always wrestled with these difficult situations, but usually independently. The same concerns that face the team, that is, undesirable features associated with existing alternatives, have plagued the school psychologist. Using a team approach does not reduce the difficulty, it just involves more people in reaching

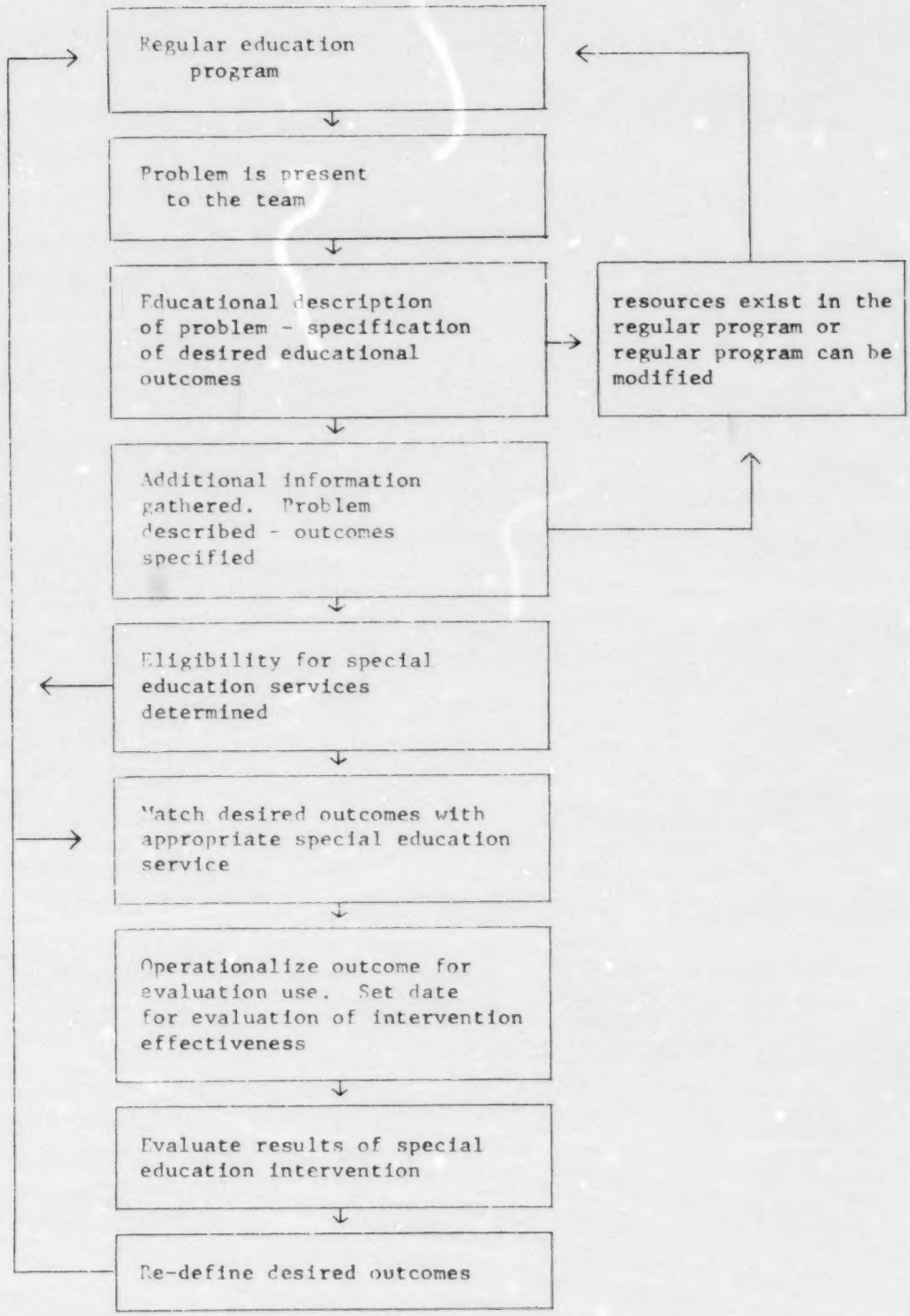
Regular education program
Problem is present to the team
Educational description of problem - specification of desired educational outcomes
resources exist in the regular program or regular program can be modified
Additional information gathered. Problem described - outcomes specified
Eligibility for special education services determined
Match desired outcomes with appropriate special education service
Operationalize outcome for evaluation use. Set date for evaluation of intervention effectiveness
Evaluate results of special education intervention
Re-define desired outcomes

Figure 3
Process for making intervention decisions

a decision and makes more people aware of the limitations associated with a decision. In addition to making better decisions, increased awareness may permit school personnel to minimize the effects of the limitation by compensating for it where they can. For example, the team might decide that a child needed the services of a resource teacher to improve his academic functioning. Associated with that decision could be the concern that the child might loose his social position in the peer group because of the amount of time and the times that he would be gone from the classroom. Even though the major objectives for the child were academic in nature, the teachers would be in a better position to promote and create opportunities for continued peer group involvement because of their awareness of this possible problem. Also, because of increased sensitivity to the problem, the teachers would be in a better position to observe any change in peer relations.

The second outcome of having more people aware of the limitations of decisions would be the accumulation of information important for such activities as altering the nature of the curriculum structuring of building level services, determining staff development priorities, and securing additional learning resources. The school psychologist through working with children with problems has gathered insight into how attendance centers could change to better serve all children. Unfortunately, unless others who work in that attendance center encounter the limitations that exist, they may remain unaware or their priorities may be different.

The team approach is perhaps the highest form of professional risk taking. Observations and opinions that were once unchallenged because of operating procedure are thrown on the table where they will be open for review. The benefits seem to far outweigh the disadvantages. Evolving from this approach should be better decisions for children resulting in better services. And, because of the recognition of limitations that exist in program alternatives, a greater openness toward evaluation and review of pupil progress should develop. These are two major, direct benefits to children. The indirect benefits should include the staff development of everyone participating in the process and the heightened visibility of limitations that exist in the school building. Such benefits are greater than we have received from the practices that we have used in the past.

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WHERE DO WE GO FROM HERE?

In this paper the problem of defining mental retardation, recent legal actions in special education, educational programming, and evaluation and diagnosis have been discussed. No such discussion is going to eliminate the difficulties that currently confront professionals working in the area of mental retardation. Hopefully, two things have been accomplished. The first is that the complex variables contributing to our problems can be better understood, improving our ability to respond effectively and productively. The second is that some specific implications for our professional activities and priorities can be seen that can be acted on.

Two major substantative concepts were presented regarding mental retardation that bear repeating. The first is the relativity of mental retardation. What is ultimately to be considered retarded functioning not only includes characteristics of the individual, but it also includes characteristics of the environment in which the individual is required to function. This means that individuals who are constitutionally the same, but who are required to function in different environments may be classified differently. Thus, ability to adapt to one's environment plays a key role in the determination of mental retardation. In addition to intellectual variables, diagnosis in the school situation must consider the requirements of the child's school environment. It is this school functioning that is of the most concern to the school psychologist.

The second concept is that mental retardation is a measure of current functioning only. This is often difficult to understand because many children diagnosed as mentally retarded will not sufficiently improve in adaptive behavior to warrant re-classification. It would seem that this point-in-time classification of mental retardation, i.e., that the diagnosis can change, would be most important to us. It provides for optimism that should be part of any treatment program, the hope that with a well designed program the individual's behavior may change and he will no longer be considered handicapped. Also, if we believe that mental retardation is a measure of current functioning, our efforts to provide appropriate and periodic re-evaluation should be serious and should center around the individual's adaptive behavior.

Throughout this paper an emphasis has been placed on instructional alternatives, teaming, and team decision-making. It would be unfortunate if this content was treated as educational philosophy that was not practical in the real world. Granted, it would be difficult to locate many places in Iowa where a complete Cascade System of Special Education Services exists. Also, a team approach to making educational decisions is used in few school buildings and almost no total school system in Iowa. However, we do have the advantage of having in operation most of the components of the Cascade System throughout the state. Also, we have the personnel to use the team process that has been discussed. With the Cascade System, our task is to fill in the missing services.

With the team process, our task is to learn to make decisions cooperatively. It would seem that a true continuum of services could not exist outside of an environment that embraces the team process. Without the team process, we are back to having rigid programs that inhibit the movement of children upward or downward on the continuum based on their individual needs.

The tasks of implementing the Cascade System and team process are too great to accomplish overnight. Heavy reliance is placed on the team process to improve services and to eliminate many of the things that we currently dislike. The decision making, the product of the team approach, cannot be legislated, regulated by the state, or mandated by school administrators. Such actions can and hopefully will facilitate the team process, but, it is the learned ability to function in a cooperative environment that is crucial to its effectiveness. It is the people involved who make the difference.

In making the difference, the school psychologist plays a fundamental role. Individually, his contributions are important to the success of any team process. In addition to the attitudes and actions of the school psychologist, he is in a position to lead the way for others. This leading can take two forms. The first is providing behavior for others to model after. The discussion of courts and also the team process should provide insight for changes in professional practices that should be made. By making at least some of these changes in our practices, people who are still saying that it should be done can be shown that it can be done. Many changes are within the power of the individual school psychologist to make.

The second form of leadership takes the form of the school psychologist serving as a catalyst, an action agent. Inservice training of teachers, participation in establishing priorities for special education units and local schools, providing data to schools on the problems that children are experiencing, and sharing information on such things as due process and the Cascade concept with principals and superintendents are all forms of this leadership. Many school psychologists have been doing this, many have not. To perform effectively as a catalyst requires a degree of public relations skill that some school psychologists have ignored. Even where public relations skills have been present, singleness of purpose generally has not been present. For the change to occur that the school psychologist is seeking will require persistence and a limiting of the requests for change that are made on a school. Bombarding a school with too many ideas and too much information may prevent any positive change from occurring because the school is moving in too many directions at once. Where change has not occurred, it may be because the school psychologist has seen himself as a dispenser of information instead of as a catalyst for directed change.

The leadership role of the school psychologist involves more than promoting a change that will be beneficial to children. The selection of the type of change that is most appropriate for a school building or school system must precede any promotion. Determining what changes are

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appropriate involves looking at priorities, readiness and feasibility for success. The kind of relativity that exists in mental retardation also exists in determining the changes that a school building could profit most from. Staffing patterns, curriculum, teacher attitudes, and available leadership all differ and help to determine what the first step should be. The fact that school buildings are not all alike is what makes the role of the school psychologist so important. He is the major representative of special education involved with school buildings because he is the one contacted when children first experience difficulties in school. His involvement at the building level should provide insight necessary to identify and prioritize areas for positive change.

The ability of the school psychologist to generate change is related to his ability to demonstrate behavior that others can and want to model. The day-to-day interaction with building personnel, emphasis on adaptive behavior, and emphasis on involving others in the decision-making process along with the results he produces for children will color the attitudes of others toward his suggestions. Effectiveness as a school psychologist is interwoven with the ability to serve as a model and a catalyst.

The major problems that confront us, providing due process and appropriate instructional alternatives, belong to many people. The legislature, Department of Public Instruction, directors of special education, and building principals are only a few of the parties involved. For many reasons there is no individual professional that is in a better position to initiate new direction than the school psychologist. With the opportunity to act comes the responsibility to attempt to provide new direction or to remain silent at the failures of others and uncritical of the current order of things.

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APPENDIX A

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Major Statewide Services in Mental Retardation*

General health, education and welfare services that are available on a statewide basis and that are used most frequently by workers in mental retardation are listed in the following material. Some of the agencies have regional offices and others do not. In addition to the services listed, there are community sponsored services in many locales that serve mentally retarded individuals.

Statewide services are listed under nine headings: Diagnostic Services, Health Services, Counseling and Welfare Services, Residential Care Services, Educational Services, Rehabilitation and Employment Services, Consultation on Program Development, Coordination of Services and Voluntary Organizations on mental retardation. Following each service is an address or addresses through which additional specific information can be obtained.

DIAGNOSTIC SERVICES

Child Development Clinic

The Child Development Clinic is an outpatient facility and is a division of the Department of Pediatrics in the University Hospitals. All referrals to the Clinic must be made by a physician.

The primary role of the Child Development Clinic is as a diagnostic clinic for developmental problems in children. Once the diagnosis is made, the child is referred back to his personal physician and the resources of the local community with appropriate recommendations. In selected cases, short-term therapy may be provided by the Clinic if no local resources are available.

The Clinic will provide a comprehensive study on any child under 17 years who has:

1. Problems suggestive of mental retardation;
2. Problems associated with poor school performance; or
3. Psychological problems associated with medical conditions.

Child Development Clinic
University Hospital School
Iowa City, Iowa 52240

Glenwood and Woodward State Hospital-Schools

Each of the two state hospital-schools offer diagnostic and evaluative services for the half of the state for which they are responsible. A comprehensive evaluation is offered to any person suspected of being

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*Adapted from Introduction to Statewide Service for the Mentally Retarded in Iowa, Boswell, Caster & Lange, November, 1968.

mentally retarded and a specific and realistic program is outlined to meet such an individual's needs within the hospital-school or the community. Since the Code of Iowa requires an evaluation prior to any admission, the clinic also determines such eligibility. Further, pupil-patients on leave from the hospital-school in foster homes or on work placements may use the services of the clinic if they encounter difficulty in their adjustment.

All applicants for evaluation are initiated through the office of the county designate, who is appointed by the county board of supervisors. The designate is generally the director of the county department of special services, although other responsible individuals may be appointed. Community consultants, employed by the hospital-schools, work closely with the county designates to aid in the processing of applications.

Woodward State Hospital-School
Woodward, Iowa 50276
Attention: Intake Supervisor
Diagnostic-Evaluation Clinic

Glenwood State Hospital-School
Glenwood, Iowa 51534
Attention: Director
Outpatient Services

State Services for Crippled Children

State Services for Crippled Children, established under the Social Security Act of 1935, functions under The University of Iowa. A crippled child is defined by the agency as one who has a chronic or congenital health problem which hinders the realization of his full potential. Since field clinic services are diagnostic and evaluative, the staff of examiners requests the name of the local physician or dentist who cares for the child so a confidential report and recommendations may be sent.

All Iowa children under twenty-one years of age are legally eligible for diagnostic services at a crippled children's field clinic. There is no charge to the patient for any of the clinic services. The retarded child may be seen by any one or all of the staff of pediatricians, psychologists, speech clinicians, physical therapists, nurses, and social workers. Counseling is done with families at the clinic, and followup service is provided by field consultants to assist families and personnel in the local communities to carry out recommendations, such as educational placement and referral to Vocational Rehabilitation. Patient referrals may be initiated by the parents, school personnel, nurses, or social workers with request coming from local physician or dentist. Every physician and dentist in Iowa receives a schedule of the clinics and referral forms. He sends the referral to State Services and then a notice is returned to the patient telling him of the clinic site and date, and his appointment time. Each year approximately 34 general mobile diagnostic, 15 cardiac, and 11 ENT clinics are held over the entire state of Iowa.

State Services for Crippled Children
The University of Iowa
Iowa City, Iowa 52240

HEALTH SERVICES

County Health Services

County public health nurses are employed by county boards of health. They provide nursing services on a family-centered basis for individuals and groups at home, at work, and at school. The services are available to individuals of all ages regardless of income. The nurses accept referrals from many sources; treatment and diagnostic procedures are carried out under medical direction. The public health nurse participates in planning and carries out nursing aspects of community health programs designed to prevent disease and promote health safety.

In prevention of mental retardation, the public health nurse counsels the mother during pregnancy and promotes early and continued medical care. She provides intensive followup of mother and infants at high risk in relation to mental retardation. She advocates preventive measures related to communicable diseases and promotes programs of safety in the home and community.

The public health nurse has developed a high "index of suspicion" and is effective in case finding of mentally retarded. Through the promotion of medical followup of the well child, early diagnosis of mental retardation can be made.

The public health nurse, working in the home environment, assists the family in training programs geared to the intellectual level of the child; and she assists all family members to understand and adjust to the accompanying emotional problems created in the home by the addition of a child with developmental differences of a mentally retarded child.

Division of Nursing
Iowa State Department of Health
Lucas State Office Building
Des Moines, Iowa 50319

School Health Services

School health nurses have the opportunity to interpret the child's physical or medical problems to the school personnel. Assistance is also given in the integration of medical findings in the application of medical recommendations to the school program. School health nurses employed by boards of education cooperate with county health nurses in solving the health problems of children and the family. The role that each fulfills is determined by the nature of the problem and rapport with the family.

School Health Services
Division of Special Education
Iowa State Department of Public Instruction
Grimes State Office Building
Des Moines, Iowa 50319

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COUNSELING AND WELFARE SERVICES

Iowa Mental Health Authority

The primary purposes of the Iowa Mental Health Authority (I.M.H.A.) are the following:

1. To foster the development of community operated and controlled mental health centers. This is done through I.M.H.A. staff consulting with community groups in order to assist establishing, planning, financing, and actual operation of the mental health centers. There are 21 incorporated centers in Iowa. The I.M.H.A. also plans meetings to encourage coordination of the various state and local, public and private agencies concerned with mental health. I.M.H.A. conducts quarterly meetings for boards and staff of the 21 Iowa Mental Health Centers where new developments in community mental health are considered. It collects data and information from other institutions and agencies which is then made available to the state centers.

2. To conduct surveys of needs and resources and to carry out research projects bearing on the care and treatment of Iowa's mentally ill.

3. To give assistance in training and recruiting mental health center personnel and establishing standards and qualifications for those personnel. Functioning from Psychopathic Hospital, the I.M.H.A. is in a strategic position for stimulating psychiatrists in training to locate in Iowa.

4. To promote public education. The I.M.H.A. maintains a well-stocked, up-to-date library of some 212 films and 70 pamphlets plus additional statistics and information - all available upon request to any individual or organization concerned with mental health. One of the many areas covered by the pamphlets is mental retardation. Catalog available on request.

Iowa Mental Health Authority
Psychopathic Hospital
Iowa City, Iowa 52240

County Office of Social Services

The county department of social services works closely with both the Woodward and Glenwood State Hospital-Schools providing a coordinative approach to planning of services to the retarded individual.

The staff of county department of social services provides support and counseling to both the families of and the retarded individual himself in preplacement and post-placement planning as well as life planning for noninstitutionalized retardates. The staff is expected to be knowledgeable about the problem of mental retardation and to serve as a

resource to families of the retarded in the community, finding and offering avenues of service to those who request such service.

RESIDENTIAL CARE SERVICES

Glenwood and Woodward State Hospital-Schools

Glenwood and Woodward State Hospital-Schools offer residential care for the mentally retarded residing in the half of the state that each serves. Institutional care is restricted to the mentally retarded who require specialized and intensive training, treatment and care in a structured situation requiring residential services. Residents of the state hospital-schools receive medical, psychological, social, educational, vocational leisure time and spiritual services during the period of institutionalization. Residents are returned to the community as soon as sufficient progress is made and/or when the appropriate community services are available to meet the needs of the retardate.

The Code of Iowa requires an evaluation prior to any admission to a state hospital-school. All applications for evaluation/placement are initiated through the office of the county designate, who is appointed by the county board of supervisors. The designate is generally the director of the county department of social services (although other responsible individuals may be appointed).

Woodward State Hospital-School
Woodward, Iowa 50276

Glenwood State Hospital-School
Glenwood, Iowa 51534

EDUCATIONAL SERVICES

Special Education Services

Special education services for the mentally retarded include classes for the educable and trainable mentally retarded and such ancillary services as psychological services, speech and hearing services and school social work services. Classes for the educable generally serve children with intellectual quotients between 50 and 79, and classes for the trainable generally serve children with intellectual quotients between 30 and 50. School districts may provide educational programs for mentally retarded children at the preprimary level to the age of 24.

Local school districts can meet their responsibility for mentally retarded children through services from county school systems or by contracting with other local school districts. Contractual arrangements between school systems, designed to provide educational programs for the mentally retarded, often enables sequential programming that would not be possible in any single school district. Educational programs for all handicapped pupils, which includes the mentally retarded, are required by the Code of Iowa. Such programs are to be available within local school districts, or provided indirectly through payments of tuition or other authorized expenses.

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As authorized by the Code of Iowa, public education programs for the mentally retarded are subject to the rules, regulations, and procedures established by the Division of Special Education, Iowa State Department of Public Instruction. Information concerning special education services can be obtained by contacting the local superintendent of schools, the county superintendent of schools, director of special education or other local special education personnel.

Mental Retardation Services
Division of Special Education
Iowa State Department of Public Instruction
Grimes State Office Building
Des Moines, Iowa 50319

Vocational Education Services

Vocational education is available to persons with special needs through the fifteen area community colleges and vocational technical schools in the state of Iowa. Many of the vocational programs provide the necessary orientation and training which the educable mentally retarded will need to become successfully engaged in competitive society.

Information on programs available can be obtained by contacting the Director of Student Personnel Services of the local area community college and vocational technical schools. Additional information can be obtained from the Branch of Vocational Education.

Branch of Vocational Education
Iowa State Department of Public Instruction
Grimes State Office Building
Des Moines, Iowa 50319

REHABILITATION AND EMPLOYMENT SERVICES

Rehabilitation Education and Services Branch

The Rehabiltation Education and Services Branch offers a wide range of services to the mentally retarded throughout the state of Iowa. These services include vocational training in a variety of occupations with this training being provided at both public and privately operated facilities. In addition, formal in-depth evaluation in public and privately operated centers and workshops is provided within the state of Iowa. Another common service which is provided is that of on-the-job training programs with employers.

Services to the mentally retarded are provided through district offices located throughout the state as well as through three rehabilitation centers operated by RESB. Full-time counselors are also assigned to a number of special education programs throughout the state and the two state hospital-schools. The state office RESB also has one full-time person with total responsibility in the area of rehabilitation of the mentally retarded.

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Rehabilitation Education and Services Branch
801 Bankers Trust Building
Des Moines, Iowa 50309

Iowa Employment Security Commission

Most counselors, selective placement specialists, and some interviewers in this agency have received special training on mental retardation and on service to the educable retarded. These staff people have participated in seminars and institutes at Glenwood, Woodward and at the University of Iowa. In our Class II and Class III offices, it can be assumed that one or more staff people are trained in service to this special applicant group.

Services available are counseling, testing, selective placement, special job development, and training.

In many areas, employment service personnel work closely with special education directors or workstudy program coordinators to provide orientation to the world of work, group training in job search techniques, counseling to develop vocational goals, and referral to training facilities. Printed materials on the subject have been prepared by the Department of Labor and available on request.

Iowa Employment Security Commission
1000 East Grand
Des Moines, Iowa 50319

Governor's Committee on Employment of the Handicapped

The Governor's Committee on Employment of the Handicapped was made statutory by action of the 61st General Assembly. The purpose of the Committee is to promote employment of the handicapped through a continuing program of public information and education and by cooperating with all groups interested in employment of the handicapped.

The Governor's Committee is engaged in the organization of committees at the local level, realizing, that problems of employment for the handicapped will be solved in the communities in which they reside.

Governor's Committee on Employment of the Handicapped
Grimes State Office Building
Des Moines, Iowa 50319

CONSULTATION ON PROGRAM DEVELOPMENT

Bureau of Mental Retardation Services

A major aspect of the function of the Bureau of Mental Retardation Services is the development of community programs for the mentally retarded. Community Mental Retardation Specialists consult with individuals, agencies, and organizations on the following:

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1. Obtaining diagnostic evaluations on mentally retarded children and adults;

2. Appropriate program resources for children and adults in cooperation with local and state agencies;

3. Formulation and organization of local projects designed to develop facilities to serve the retarded locally or on an area basis.

Community Mental Retardation Specialists are available on all problems relating to mental retardation. Assistance can be obtained by contacting the County Department of Social Services.

Bureau of Mental Retardation Services
State Department of Social Services
Lucas State Office Building
Des Moines, Iowa 50319

VOLUNTARY ORGANIZATIONS

Iowa Association for Retarded Children

The Iowa Association for Retarded Children is a voluntary nonprofit association, organized in June 1953 for the purpose of influencing the attitudes and opinions of society toward the provision of better resources and services to help the 84,000 mentally retarded children and adults of Iowa.

The organizational structure consists of 86 local county units or chapters serving 91 counties in Iowa, with representation in the additional eight Iowa counties. The members of local county units are members of the Iowa and National Associations for Retarded Children. In this manner, each Iowa county has had a part in any accomplishment in behalf of the retarded because the Iowa Association for Retarded Children is an extension of each local county or unit and operates through representatives elected by them to serve on the State Board.

The Association acts to motivate and support state agencies in their programs to serve the needs of the mentally retarded. It gives guidance and coordination to the programs of local county chapters. It stimulates research and studies in the field of mental retardation. It functions in creating awareness of the needs of the retarded through a public education program. It helps to implement local and state programs and services.

For further information, we suggest that you contact the Assocation.

Iowa Association for Retarded Children
1707 High Street
Des Moines, Iowa 50309